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July 24, 2007

To: Supervisor Zev Yaroslavsky, Chairman
Supervisor Gloria Molina
Supervisor Yvonne B. Burke
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

REPORT ON RESIDENCY SLOTS AT MARTIN LUTHER KING, JR. - HARBOR HOSPITAL AND ACTIONS TO PRESERVE SLOTS

On July 17, 2007, your Board approved Supervisor Burke's motion directing my office, working in concert with County Counsel and the Department of Health Services (DHS), to analyze and report back with findings and recommendations on the medical residency slots at Martin Luther King, Jr. - Harbor Hospital (MLK-H) and what legislative action would be required to reserve the resident slots if there is no existing process for reinstatement. We were further directed to actively pursue legislative action, as required, if that action is needed.

STATUS OF RESIDENTS PRESENTLY UTILIZING RESIDENCY SLOTS

Of the 171 residents who required placement to complete training, 168 have been placed. Additionally, 82 residents (including 7 off-cycle residents) will complete their training on or before November 1, 2007. Attachment I is a more detailed matrix of the MLK-H Resident Placement Project.

CONGRESSIONAL HISTORY REGARDING RESIDENCY SLOTS

As part of the Balanced Budget Act of 1997, Congress created a series of limits on the number of residents for which Medicare would pay. One limit is based on the number of physician residents at the hospital during its 1996 fiscal year. Under the 1997 legislation, this absolute cap on the reimbursable number of physician residents is compared to the average number of residents actually being trained during the current year and two previous years (i.e., rolling three year average). The hospital is then paid for the lower of these two numbers.

According to the Conference Committee report, Congress had two sometimes competing goals in passing these provisions. The first, and perhaps primary, goal was to cap the number of reimbursed residency slots in the country at the 1996 level. The second goal, which was codified in the statute, was to allow some flexibility for the creation of new programs. Although Congress has tinkered with these provisions several times since they were originally passed, the essential goals do not appear to have changed.

The Centers for Medicare and Medicaid Services (CMS) has established implementing regulations which limit right to reimbursement for residency slots added after 1996 to three situations. The only one potentially applicable to the situation at MLK-H is for a hospital with no residency programs in 1996 which adds a newly approved residency training program (see 42 C.F.R. § 413.86(g)(6) (1998). Over time, CMS has liberalized the regulation slightly. However, CMS' regulatory changes have been narrowly tailored and have adhered to a goal of keeping the number of reimbursed residency positions limited.

CMS believes that the limits imposed by Congress are tied specifically to a particular hospital. According to staff at CMS, when a particular provider agreement terminates (i.e., is surrendered and not reassigned to a new owner), the provider's reimbursable residency slots are also terminated. Accordingly, under the current rules, if MLK-H's provider agreement were to terminate, a new operator at the site of MLK-H would only be able to receive reimbursement for residents recognized under the new hospital provisions of the regulations.

The formula for calculating the number of residents basically looks at the number of residents in training each year, and the minimum length of time that the program takes to complete. The regulation is clear; however, that an urban hospital may not receive reimbursement for residents added in programs established more than 3 years after the first program began. Because hospitals usually add different types of residency programs over time, as opposed to starting all its programs in the same year, this later rule is a substantial barrier to any new operator receiving reimbursement for the same number of residents or the same range of programs as MLK-H.

LEGISLATIVE ACTION TO PRESERVE MLK-H RESIDENCY SLOTS

The rule that limits hospitals to the number of residents in training within 3 years of the date the first program starts is not mandated by statute, and theoretically could be changed by CMS. However, it is consistent with Congress' intent and CMS has expressed reluctance to change it. Narrowly tailored legislation, therefore, would be beneficial as it would assure that CMS had the authority it needs to act and it would make such actions mandatory.

The purpose of a legislative change would be specifically to allow a new operator of MLK-H to have access to the same number of reimbursable residency slots as MLK-H regardless of when the residents begin their training at that site. This could be accomplished several ways, including the placement of residency slots in abeyance, and then reassigning them to the new operator. That, however, is cumbersome and potentially at odds with the temporary cap transfers that have been done to accommodate the MLK-H residents who have moved to other hospitals to complete their training. The most straightforward approach is simply to amend Section 1886(h)(4)(H) of the Social Security Act specifically to allow a new operator which opens a facility on the MLK-H site to have the right to be reimbursed for up to the same number of slots as MLK-H had before its residents were transferred out.

This right would not be time-limited; thus, the problem of instituting a lot of new training programs simultaneously to meet the three year deadline in current regulations would be avoided. The amendment should also include a new temporary exception to the rolling three-year average to avoid penalizing the programs because they are new. Nothing in the legislation would, however, require the new operator to have graduate medical education programs or would authorize reimbursement for more residents than are actually being trained.

We understand that several Members of Congress may be interested in assisting the County with such legislation. DHS has provided them with our thoughts on the specific language which would achieve the objective of allowing a new operator on the MLK-H site to have the ability to be reimbursed for up to 250 residents if, over time, it develops physician training programs with that many participants. A copy of that draft language is included as Attachment II.

If you have questions or need additional information, please contact me or your staff may contact Sheila Shima, Deputy Chief Executive Officer, at (213) 974-1160.

WTF:SRH
SAS:bjs

Attachments

c: Executive Officer, Board of Supervisors
County Counsel
Director and Chief Medical Officer, Department of Health Services
Director of Personnel

MLK RESIDENT PLACEMENT PROJECT
STATUS AS OF JULY 23, 2007

Resident Placement and Scheduled Graduations

Residents in Drew and County sponsored programs (medicine and dental residents)	253
Residents "pre-matched" to Drew programs to start July 1, 2007	10
Residents who completed training as of June 30, 2007	75
Number of residents who will graduate "Off-Cycle" in 2007	7 *

County Sponsored Programs Transfer to Harbor/UCLA Sponsorship

General dentistry residents	4
Oral maxillofacial surgery residents	7

Permanent Placement Project

Residents not scheduled to graduate/Permanent placement required	171
Residents placed	168
Residents not placed	3 **
Residents placed ***in California***	84
Residents placed in DHS residency programs	11
Number of medical centers accepting Drew sponsored residents	69 ***
Number of residents expected to graduate in 2008	74
Number of residents expected to graduate in 2009	70
Number of residents expected to graduate in 2010	14
Number of residents expected to graduate in 2011	2

CMS Temporary "Cap" Transfer

CMS temporary cap transfer requests	158
CMS temporary cap transfers finalized to date (with waivers)	129
CMS temporary cap transfers pending DHS processing	29

Resident Completion of County General Release Form

Waivers completed by residents not graduating	166****
Residents requesting cap transfers pending DHS processing	12

FOOTNOTES

* Seven residents will graduate "off-cycle" -- County will continue resident compensation as they complete training requirements in 2007.

** 3 residents were not placed: 1 Pediatric resident initiated a medical leave/elected not to interview; 1 Psychiatry resident interviewed but was not selected for placement; 1 Anesthesiology resident was not selected for any interview.

*** Loma Linda University Medical Center took the largest number of Drew residents (26); followed by Cedar-Sinai (19); and Christus Spohn Corpus Christi (12).

**** This total includes the count of residents who signed the County's "Waiver". The residents fall into 5 categories: graduates; residents completing training in 2007 "off-cycle"; residents requesting CMS temporary cap transfer; residents <u>not</u> requesting CMS temporary cap transfer; and residents not yet placed. County <u>required</u> residents to complete the County Waiver only if: 1) they requested the CMS temporary cap transfer to support their placement into another program, and 2) they requested salary continuation to support their training ("off-cycle") during 2007.

PROPOSED LEGISLATIVE LANGUAGE ON RESIDENCY SLOTS

The following text would be added as Section 1886(h)(4)(H)(v) of the Social Security Act [42 U.S.C. Section 1395ww(h)(4)(H)(v)]

In the event that the provider agreement of Provider No. 05-0578 is terminated and another hospital, whether under the same or different ownership, later enters into a provider agreement pursuant to Section 1866(a) to provide hospital services on the same physical site used by Provider No. 05-078, the limitation on the number of total full time equivalent residents under subparagraph (F) and paragraphs (d)(5)(B)(v) and (vi) applicable to such new provider shall be equal to the limitation applicable to Provider No. 05-078 [on July 1, 2006] [on the last day Provider No. 05-0578's provider agreement was effective] under subparagraph (F) and paragraph (7). Further, the provisions of subparagraph (G) and paragraph (d)(5)(B)(vi)(II) shall not be applicable to such new provider for the first three years in which such new provider trains residents under any approved medical residency training program.